The Medical Board of California and the Future of its Diversion Program

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On July 26, 2007, the MBC voted unanimously to abolish its current Diversion Program for substance abusing licensees, effective June 30, 2008. I have had positive feedback from several individuals from within our state as well as from other states concerned about similar issues, but, because the decision has been greeted with dismay in some quarters, I would like to share with you the basis for the board's action and its future plans regarding impaired physicians.

In 1980, the California Legislature enacted a law requiring the Medical Board to "seek ways and means to identify and rehabilitate physicians with impairment due to abuse of dangerous drugs or alcohol, so that physicians so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety." *It needs to be noted that the public health and safety was not to be compromised as a result of this new law*. In the same statute, the Legislature created within the Medical Board a new "Diversion Program" which would "divert" substance abusing physicians from the disciplinary tract and instead monitor their behavior and medical practice while they recover from their addiction. Participants, most of whom participate in absolute confidentiality, enter into a contract with the program in which they agree to abstain from drugs/alcohol and to comply with program rules. The program utilizes a number of mechanisms, including random drug testing, required attendance at group therapy meetings, and required "work site monitors," when participants are allowed to practice medicine to determine participant compliance with the terms of the contract. Since its inception, the program has been administered by board employees, assisted by a large cadre of service providers (local specimen collectors, group meeting facilitators, and testing laboratories) and volunteers across the state. The Bureau of State Audits reflected 14 fulltime Medical Board staff and a budget of $1.4 million. The real number of individuals with expertise to operate this program was more than 100, most of them providing service at no cost. If some reasonable cost was put in for those individuals, the budget would be far more than what is seen in the audit, which shows the more true size and scope of the Diversion Program.

During the first decade of the program's existence, the State Auditor General examined the performance of the program three times and reached troubling conclusions. In 1982, 1985, and 1986, the Auditor General consistently found that the program was not adequately monitoring participants and failed to terminate the participation of physicians who did not comply with their contracts. Obviously, failure to monitor a substance abusing physician would expose the patients of that physician to great risk. Additionally, the Auditor General found that the Medical Board had failed to establish clear standards for the program and did not adequately oversee the program.

After each audit, the board attempted to improve the program by implementing the recommendations of the Auditor General. However, 18 years elapsed before the next external audit of the Diversion Program. In November 2004, the Medical Board

Enforcement Monitor released the findings of her investigation of the program, findings that were consistent with those of the Auditor General nearly two decades earlier. Specifically, the monitor found that: 1) the program did not adequately monitor the substance abusing physicians who are participating in it, 2) the monitoring mechanisms used, particularly its drug testing programs and work site monitoring standards, were ineffective and inadequately administered, 3) the Medical Board had failed to establish policies that are consistently followed by the Diversion Program in terms of consequences for relapses and criteria for termination from the program and, 4) the Medical Board did not adequately oversee the program.

Disturbingly, and very sad to me, the Enforcement Monitor found that the program's lax administration enabled participants to "game" its monitoring mechanisms. Drug testing was not always performed randomly, but at times was regularly done on days that could be anticipated by participants who could adjust their behavior accordingly. The program failed to establish sufficient standards and qualifications for "work site monitors" such that a non-physician hired and fired by a participant could be approved to oversee that participant's practice of medicine. The vast majority of worksite monitors and treating psychotherapists failed to file the required reports of their observations and the program was so chronically understaffed that many of these problems were not detected, much less addressed.

In its 2005 response to the Enforcement Monitor's report, the California Legislature imposed a June 30, 2008 "sunset date" on the Diversion Program. In other words, the Legislature gave the board two additional years to remedy the serious deficiencies identified by the monitor. The Legislature also ordered its own auditors, the Bureau of State Audits (BSA), to examine the performance of the program during the first half of 2007, to ensure that any changes made by the board were effective in improving the program. The Medical Board, working with executive staff, hired a new program administrator and increased its budget an additional $500,000 in 2005-06 for new staffing and resources for the Diversion Program.

The BSA audit was released on June 7, 2007. Consistent with four earlier audits, the BSA found that the program's monitoring of its substance abusing participants remained inconsistent; its oversight of the drug testing program and its service providers (especially worksite monitors) was inadequate; and the Medical Board had not properly overseen the program. In response to the BSA's survey regarding the program's drug testing system, one participant replied, "mine wasn't very random. I was able to game it for several years and almost 'graduated' while still using." This mirrored to the board the human element that would never allow us to reach a standard of zero tolerance. This was the standard set without exception by the enforcement monitor and others. Essentially, the Medical Board has to warranty to all consumers that they are completely safe to see participants in the Diversion Program, and they will not suffer from participants' addictions.

On July 26, 2007, the Medical Board met to decide the fate of the Diversion Program. We listened thoughtfully to over two hours of public comment. Physician professional

associations urged us to retain the program as part of the board; while victims of botched surgeries performed by Diversion Program participants urged abolition of the program, as did the former Enforcement Monitor. Following another two hours of debate, the board voted unanimously to end the program as it currently exists, and I urged, and we agreed, to convene a presidential summit later this year to discuss ways to implement the "diversion" concept while protecting patients.

We, the 2007 Medical Board, inherited the problems of the Diversion Program but could not resolve them despite our best efforts. We could not ignore the results in the current BSA audit as well as previous failed audits, anymore than we could ignore the testimony of the patients who had been injured by Diversion Program participants while being denied an opportunity to protect themselves from those participants shielded by the secrecy provided by the Diversion Program.

We also could not ignore the board's statutory mission. When the Diversion Program was created in 1980, the Medical Board's highest priority (as then expressed in Business and Professions Code section 2229) was "physician rehabilitation" and the "diversion" concept seemed consistent with that priority. However, the Medical Board's statutory mandate changed with the 1990 passage of SB 2375 (Presley) and its amendments, section 2229. Public protection is the Medical Board's highest priority; the statute also says that when public protection is inconsistent with physician rehabilitation, public protection is paramount. The operation of a diverting program which demonstrably does not adequately monitor substance abusing physicians, while concealing their participation from patients, is obviously inconsistent with that mission.

Since we made our decision, I have heard expressions of dismay and bewilderment from some in the physician community who characterize the vote as a "rejection of the recognition that addiction is a disease." Our action has nothing to do with whether addiction is a disease. It has only to do with whether the Diversion Program protected patients, and five out of five external audits had found that it did not. That, very simply, is why the Medical Board could not continue to operate the Diversion Program.

At the upcoming summit, the Board will welcome the input of interested parties like the general public, the California Medical Association, the California Society of Addiction Medicine, the California Psychiatric Association, the Center for Public Interest Law, and patient advocacy groups. We intend to re-examine the threshold issues: 1) whether – and under what conditions – confidential "diversion" from discipline is possible within a public protection mandate; and 2) whether such a program should be operated by a state agency or a private entity. I also want to suggest that we consider the possibility that there be a statewide program for all healthcare professionals and possibly all professionals within our state that administers policies directed at this issue. We look forward to these challenges.